MEDICAL HISTORY QUESTIONNAIRE

VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE

HIPP Program (Health Insurance Premium Payment)

Name _____ (please print) Case Worker: _____

Medicaid Case ID _____

In order for the Department to determine whether payment of your private health insurance premium is cost-effective, please provide the following information and return it along with your HIPP application in the enclosed self-addressed stamped envelope. All information is confidential.

1. Have you or anyone else for whom you are requesting Medicaid (the assistance unit) been hospitalized in the past two years?

   Name _____ Reason _____ How many times? _____

2. Does anyone in the assistance unit require regular doctor's visits?

   Name _____ Reason _____ How many times per year? _____

3. How many prescriptions are filled each month for persons in the assistance unit?

   _____ Total amount per month $_____

4. Are any of the persons in the assistance unit periodically institutionalized or living in an institution (mental health home, nursing home, hospital, etc.)

   Name _____ Type of Residence _____

5. Does anyone in the assistance unit have any of the following medical conditions which requires medical care? Check all conditions which apply:

Condition (check any which apply)	If checked, list name of person with this condition	How often is medical care required?
Pregnancy ☐		
Diabetes ☐		
Blood Disorder ☐		
Cancer ☐		
Mental Illness or Retardation ☐		
Heart Condition ☐		
Asthma or other Respiratory Ailment ☐		
Scoliosis or Back Problems ☐		
Stroke or Head Injury ☐		
Organ Transplant ☐		
Seizure Disorder ☐		
Kidney or Liver Disorder ☐		
Alcoholism/Drug Addiction ☐		
HIV positive ☐		
Other disease or condition requiring treatment (describe) ☐		

6. Are any of the conditions checked above limited or excluded under your current plan or the plan for which you are eligible, for pre-existing or other reasons?

Describe _____

Signature _____ Date _____

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